DEPENDENT CONTINUATION OF GROUP HEALTH COVERAGE (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 53883 (09/05)

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Sec. 3402. The individual's social security number will be used for tax reporting and as an identification number.

NDPERS • PO Box 1657 • Bismarck, • North Dakota 58502-1657
(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920

PART A COBRA MEMBER INFORMATION (Spouse or Dependents Losing Coverage)

Name (Last, First, MI)		Social Security Number	
Date of Birth	Gender ☐ Male ☐ Female	Home Telephone Number	
Address	City	State	Zip + 4

PART B TRANSFERRING FROM POLICY HOLDER

Name (Last, First, MI)	Social Security Number

PART C QUALIFYING COBRA EVENT

☐ Age 23, no longer full-time student and financially dependent ☐ Age 26 ☐ Married ☐ Divorce from current contract holder ☐ Termination of current contract holder ☐ Death of current contract holder ☐ Contract holder entitled to Medicare	Date of Event:

PART D ELECTION

Do you wish to continue your current coverage in the NDPERS Health Plan? ☐ Yes ☐ No If Yes, at what Level of Coverage: ☐ Self Only ☐ Self & Child(ren) List all family members to be covered below.	Effective Date (Mo/Yr)

Name	*Relationship*	*Gender*	*Date of Birth*	*Social Security No.*

PART E AUTHORIZATION

Dependents losing eligibility may continue the NDPERS Group Health Coverage at their own expense for a maximum of 36 months.

PAYMENT OF PREMIUM:
NDPERS will send you monthly premium notices. You have the following premium payment options.

1. To have your monthly premium withheld from a bank account complete the Authorization for Automatic Premium Deduction (SFN 50134).
2. You may submit your personal check for the monthly premium to NDPERS by the 15th day of each month.

Failure to remit your premium by the due date will result in loss of coverage.

I have read this application in its entirety **(including the back page)** and certify the information is accurate and complete. I understand and agree that any false statements or omissions may void any benefit plans insured based on this application.

COBRA Member Signature _____ Date _____

PART F NDPERS USE ONLY

Group Number	Month the last health insurance premium will be paid:	Begin Date	End Date

ORIGINAL TO NDPERS – PLEASE MAKE A PHOTOCOPY FOR YOUR RECORDS